		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041871

Facility Name: PROVENA ST JOSEPH CENTER

Address: 659 E JEFFERSON (Number) FREEPORT (City) 61032 (Zip Code)

County: STEPHENSON

Telephone Number: 815-232-6181 **Fax #**

IDPA ID Number: 371127787011

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Karl Baker **Telephone Number:** (314) 231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Connie S. March
(Title) President

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,230	0	2,870	20,100	8
9	SNF/PED	0	0	0		9
10	ICF	0	20,216	0	20,216	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	17,230	20,216	2,870	40,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.05%

D. How many bed-hold days during this year were paid by Public Aid?
130 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,870

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	264,428	1,092	31,112	296,632		296,632		296,632			1
2	Food Purchase		211,749		211,749		211,749	(3,720)	208,029			2
3	Housekeeping	100,602	37,841	666	139,109		139,109		139,109			3
4	Laundry	100,074	2,194	14,063	116,331		116,331		116,331			4
5	Heat and Other Utilities			177,206	177,206		177,206	3,459	180,665			5
6	Maintenance	83,179	13,736	60,294	157,209		157,209	749	157,958			6
7	Other (specify):*	21,100	912		22,012		22,012		22,012			7
8	**TOTAL General Services**	569,383	267,524	283,341	1,120,248		1,120,248	488	1,120,736			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,673,261	72,161	153,608	1,899,030		1,899,030	(19)	1,899,011			10
10a	Therapy			190,917	190,917		190,917		190,917			10a
11	Activities	66,172	753	525	67,450		67,450		67,450			11
12	Social Services	53,592	134	591	54,317		54,317		54,317			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,793,025	73,048	353,441	2,219,514		2,219,514	(19)	2,219,495			16
	C. General Administration											
17	Administrative	177,951	1,654	674,553	854,158		854,158	(299,362)	554,796			17
18	Directors Fees											18
19	Professional Services			100,907	100,907		100,907	30,624	131,531			19
20	Dues, Fees, Subscriptions & Promotions			13,116	13,116		13,116	3,061	16,177			20
21	Clerical & General Office Expenses		12,516	25,488	38,004		38,004	(34,125)	3,879			21
22	Employee Benefits & Payroll Taxes			667,232	667,232		667,232	42,885	710,117			22
23	Inservice Training & Education			12,255	12,255		12,255	1,791	14,046			23
24	Travel and Seminar			6,044	6,044		6,044	4,821	10,865			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,386	38,386		38,386		38,386			26
27	Other (specify):*			89,353	89,353		89,353	(89,353)				27
28	**TOTAL General Administration**	177,951	14,170	1,627,334	1,819,455		1,819,455	(339,658)	1,479,797			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,540,359	354,742	2,264,116	5,159,217		5,159,217	(339,189)	4,820,028			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA ST JOSEPH CENTER #0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			166,496	166,496		166,496	(85,776)	80,720			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							174,047	174,047			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							11,788	11,788			34
35	Rent-Equipment & Vehicles			14,877	14,877		14,877	263	15,140			35
36	Other (specify):*											36
37	**TOTAL Ownership**			181,373	181,373		181,373	100,322	281,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			468,960	468,960		468,960		468,960			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			534,660	534,660		534,660		534,660			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,540,359	354,742	2,980,149	5,875,250		5,875,250	(238,867)	5,636,383			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,076)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(89,258)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(13,090)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(89,353)	27		24
25	Fund Raising, Advertising and Promotional	(796)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,573)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,295)	Var	34
35	Other- Attach Schedule	(30,999)	Var	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (41,294)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,867)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROVENA ST JOSEPH CENTER

ID# 0041871

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Marketing Benefits	$ (2,166)	22	1
2	Non-Allowable Marketing Benefits	477	22	2
3	Non-Allowable Marketing Benefits	53	22	3
4	Non-Allowable Marketing Benefits	144	22	4
5	Non-Allowable Marketing Related Expense	(2,331)	17	5
6	Non-Allowable Marketing Related Salary	(26,516)	21	6
7	Non-Allowable Marketing Benefits	0	22	7
8	Non-Allowable Marketing Related Expense	(510)	21	8
9	Non-Allowable Marketing Related Expense	(150)	21	9
10	Non-Allowable Marketing Related Expense	0	17	10
11	Non-Allowable Travel Expense	0	24	11
12	0	0		12
13	0	0		13
14	0	0		14
15	0	0		15
16	0	0		16
17	0	0		17
18	0	0		18
19	0	0		19
20	0	0		20
21	0	0		21
22	0	0		22
23	0	0		23
24	0	0		24
25	0	0		25
26	0	0		26
27	0	0		27
28	0	0		28
29	0	0		29
30	0	0		30
31	0	0		31
32	0	0		32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,076)	1,356	0	0	0	0	0	0	0	0	0	(3,720)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,459	0	0	0	0	0	0	0	0	0	3,459	5
6	Maintenance	0	749	0	0	0	0	0	0	0	0	0	749	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,076)	5,564	0	0	0	0	0	0	0	0	0	488	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(19)	0	0	0	0	0	0	0	0	0	(19)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(19)	0	0	0	0	0	0	0	0	0	(19)	16
	C. General Administration													
17	Administrative	(2,331)	(297,031)	0	0	0	0	0	0	0	0	0	(299,362)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,624	0	0	0	0	0	0	0	0	0	30,624	19
20	Fees, Subscriptions & Promotions	(796)	3,857	0	0	0	0	0	0	0	0	0	3,061	20
21	Clerical & General Office Expenses	(40,266)	6,141	0	0	0	0	0	0	0	0	0	(34,125)	21
22	Employee Benefits & Payroll Taxes	(1,492)	44,377	0	0	0	0	0	0	0	0	0	42,885	22
23	Inservice Training & Education	0	1,791	0	0	0	0	0	0	0	0	0	1,791	23
24	Travel and Seminar	0	0	4,821	0	0	0	0	0	0	0	0	4,821	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(89,353)	0	0	0	0	0	0	0	0	0	0	(89,353)	27
28	**TOTAL General Administration**	(134,238)	(210,241)	4,821	0	0	0	0	0	0	0	0	(339,658)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,314)	(204,696)	4,821	0	0	0	0	0	0	0	0	(339,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(89,258)	0	3,482	0	0	0	0	0	0	0	0	(85,776)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	174,047	0	0	0	0	0	0	0	0	174,047	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	11,788	0	0	0	0	0	0	0	0	11,788	34
35	Rent-Equipment & Vehicles	0	0	263	0	0	0	0	0	0	0	0	263	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(89,258)	0	189,580	0	0	0	0	0	0	0	0	100,322	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(228,572)	(204,696)	194,401	0	0	0	0	0	0	0	0	(238,867)	45

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
0		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	FOOD PURCHASE	$	PROVENA SENIOR SERVICES	100.00%	$ 1,356	$ 1,356	1
2	V	3	HOUSEKEEPING-SUPPLIES		PROVENA SENIOR SERVICES	100.00%	0		2
3	V	5	HEAT & OTHER UTILITIES		PROVENA SENIOR SERVICES	100.00%	3,459	3,459	3
4	V	6	MAINTENANCE-OTHER		PROVENA SENIOR SERVICES	100.00%	749	749	4
5	V	10	NSG & MED REC-SAL-LPN		PROVENA SENIOR SERVICES	100.00%	(19)	(19)	5
6	V	17	ADMIN-SALARY-OTHER ADMIN		PROVENA SENIOR SERVICES	100.00%	166,814	166,814	6
7	V	17	ADMIN-OTHER	504,245	PROVENA SENIOR SERVICES	100.00%	40,400	(463,845)	7
8	V	19	PROFESSIONAL SERVICES		PROVENA SENIOR SERVICES	100.00%	30,624	30,624	8
9	V	20	DUES, FEES, SUBS & PROMOTIONS		PROVENA SENIOR SERVICES	100.00%	3,857	3,857	9
10	V	21	CLERICAL/GEN-SUPPLIES		PROVENA SENIOR SERVICES	100.00%	4,603	4,603	10
11	V	21	CLERICAL/GEN-OTHER		PROVENA SENIOR SERVICES	100.00%	1,538	1,538	11
12	V	22	EMP BENEFITS & PAYROLL TAXES		PROVENA SENIOR SERVICES	100.00%	44,377	44,377	12
13	V	23	INSERVICE TRAINING & EDUCATION		PROVENA SENIOR SERVICES	100.00%	1,791	1,791	13
14	Total			$ 504,245			$ 299,549	$ * (204,696)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	24	TRAVEL & SEMINAR	$	PROVENA SENIOR SERVICES	100.00%	$ 4,821	$ 4,821	15
16	V	30	DEPRECIATION		PROVENA SENIOR SERVICES	100.00%	3,482	3,482	16
17	V	32	INTEREST		PROVENA SENIOR SERVICES	100.00%	174,047	174,047	17
18	V	34	RENT-FACILITY & GROUNDS		PROVENA SENIOR SERVICES	100.00%	11,788	11,788	18
19	V	35	RENT-EQUIPMENT & VEHICLES		PROVENA SENIOR SERVICES	100.00%	263	263	19
20	V	17	ADMIN-OTHER	161,491	PROVENA HEALTH SERVICES	100.00%	161,491		20
21	V	19	PROFESSIONAL SERVICES	63,888	PROVENA HEALTH SERVICES	100.00%	63,888		21
22	V	39	ANCILLARY SERVICE CENTERS-OTH	468,960	PROVENA SEENIOR SERVICES PHARMACY	100.00%	468,960		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 694,339			$ 888,740	$ * 194,401	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SENIOR SERVICES
Street Address: 200 E COURT STREET, SUITE 200
City / State / Zip Code: KANKAKEE, IL 60901
Phone Number: (815)928-6851
Fax Number: (847)928-6160

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD PURCHASE	MGT FEE INCOME	5602865	16	$ 15,066	$	504,245	$ 1,356	1
2	3	HOUSEKEEPING-SUPPLIES	MGT FEE INCOME	5602865	16	3		504,245	0	2
3	5	HEAT & OTHER UTILITIES	MGT FEE INCOME	5602865	16	38,430		504,245	3,459	3
4	6	MAINTENANCE-OTHER	MGT FEE INCOME	5602865	16	8,321		504,245	749	4
5	10	NSG & MED REC-SAL-LPN	MGT FEE INCOME	5602865	16	(213)	(213)	504,245	(19)	5
6	17	ADMIN-SALARY-OTHER ADM	MGT FEE INCOME	5602865	16	1,853,538	1,853,538	504,245	166,815	6
7	17	ADMIN-OTHER	MGT FEE INCOME	5602865	16	448,903		504,245	40,400	7
8	19	PROFESSIONAL SERVICES	MGT FEE INCOME	5602865	16	340,270		504,245	30,624	8
9	20	DUES, FEES, SUBS & PROMOT	MGT FEE INCOME	5602865	16	42,856		504,245	3,857	9
10	21	CLERICAL/GEN-SUPPLIES	MGT FEE INCOME	5602865	16	51,149		504,245	4,603	10
11	21	CLERICAL/GEN-OTHER	MGT FEE INCOME	5602865	16	17,089		504,245	1,538	11
12	22	EMP BENEFITS & PAYROLL T	MGT FEE INCOME	5602865	16	493,092		504,245	44,377	12
13	23	INSERVICE TRAINING & EDU	MGT FEE INCOME	5602865	16	19,896		504,245	1,791	13
14	24	TRAVEL & SEMINAR	MGT FEE INCOME	5602865	16	53,573		504,245	4,821	14
15	30	DEPRECIATION	MGT FEE INCOME	5602865	16	38,693		504,245	3,482	15
16	32	INTEREST	MGT FEE INCOME	5602865	16	1,933,910		504,245	174,047	16
17	34	RENT-FACILITY & GROUNDS	MGT FEE INCOME	5602865	16	130,976		504,245	11,788	17
18	35	RENT-EQUIPMENT & VEHICL	MGT FEE INCOME	5602865	16	2,925		504,245	263	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,488,477	$ 1,853,325		$ 493,951	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA HEALTH SERVICES
Street Address: 9223 WEST ST. FRANCIS ROAD
City / State / Zip Code: FRANKFURT, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN-OTHER	DIRECT ALLOCATION			$	$		$ 161,491.00	1
2	19	)FESSIONAL SERVICES	DIRECT ALLOCATION						63,888.00	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 225,379	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PROVENA SEENIOR SERVICES PHARMACY
Street Address: 1475 HARVARD DRIVE
City / State / Zip Code: KANKAKEE, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Y SERVICE CENTERS-OTHER	DIRECT ALLOCATION			$	$		$ 468,960	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 468,960	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	PROVENA SENIOR SERVICES										174,047	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 174,047	14
15	TOTALS (line 9+line14)						$	$			$ 174,047	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA ST JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Karl Baker

TELEPHONE (314) 231-5544 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,080 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	1994	$ 1,003,500	$ 25,088	25	$ 25,088	$	$ 163,069	4
5							25				5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1996	1,409		20	141	141	775	9
10	VARIOUS			1997	14,108		20	2,243	2,243	11,172	10
11	VARIOUS			1998	2,737		20	357	357	2,124	11
12	FINANCIAL STMT DEPREC					11,192	20		(11,192)		12
13	CLF AIR CONDITIONING			1999	44,536		20	2,227	2,227	7,794	13
14	AIR CONDITIONING UNIT			1999	20,312		20	2,031	2,031	7,109	14
15	CARPET, PAD AND LIN			1999	2,077		20	415	415	1,454	15
16	RESTROOM REMODELING			1999	13,850		20	1,385	1,385	4,848	16
17	DISPENSERS (TOWEL & TISSUE)			1999	151		20	30	30	105	17
18	NONCARE PORTION OF LIMP			1999	(48,442)		20	(3,149)	(3,149)	(11,764)	18
19	RGB ARCHITECTURAL SERVICES			2000	709		20	142	142	355	19
20	SHOWERS			2000	567		20	81	81	203	20
21	ROOF (O'NEIL HALL ARCHIVE RM)			2000	1,290		20	258	258	645	21
22	FIX STEAM LEAK			2000	1,729		20	346	346	865	22
23	FIX CONDENSATE LEAK MAIN BOILER RM			2000	538		20	108	108	269	23
24	STJ COMMON AREA ASSESSMENT			2000	3,098		20	620	620	1,549	24
25	HVAC UNIT			2000	1,917		20	383	383	958	25
26	RGB MAJOR BUILDING CONSULTING			2000	5,712		20	571	571	1,428	26
27	FISCHER EXCAVATING			2000	1,605		20	321	321	802	27
28	SEALCOAT ASPHALT			2000	4,729		20	946	946	2,365	28
29	NONCARE PORTION OF LIMP			2000	(13,106)		20	(2,260)	(2,260)	(5,650)	29
30	WATER SOFTENER REPLACEMENT			2001	5,642		20	282	282	564	30
31	ALARM RELAYS, SWITCHES			2001	2,372		20	237	237	474	31
32	BATHROOM/KITCHEN REMODELING			2001	5,246		20	131	131	262	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW AIR COMPRESSOR	2001	$ 4,042	$	20	$ 202	$ 202	$ 404	37
38	STEAM LINE REPAIRED	2001	1,793		20	179	179	358	38
39	RGB ARCHITECTURAL SERVICES	2001	2,165		20	217	217	434	39
40	RGB ARCHITECTURAL SERVICES	2001	45		20	8	8	16	40
41	NEW WATER MAIN FOR ADC	2001	6,339		20	634	634	1,268	41
42	REPLACE WATER SERVICE SLA HOUSE	2001	932		20	93	93	186	42
43	BLACKTOP WORK	2001	2,650		20	442	442	884	43
44	PATCH HOLE	2001	1,542		20	154	154	308	44
45	CONCRETE PATIO	2001	550		20	28	28	56	45
46	HOT WATER HEATER REPAIRS	2001	1,614		20	81	81	162	46
47	PIPE REPAIRS	2001	1,020		20	51	51	102	47
48	NONCARE PORTION OF LIMP	2001	(21,521)		20	(1,639)	(1,639)	(3,278)	48
49	PAINT & SUPPLIES REMODELING	2002	800		5	27	27	27	49
50	KITCHEN CABINETS & WALLBOARD	2002	5,260		15	58	58	58	50
51	REPLACEMENT OF BRICKS ON HANDICAP RAIL	2002	2,055		20	17	17	17	51
52	CARPETING FOR BEDROOM & DINING ROOM	2002	672		5	45	45	45	52
53	CARPETING FOR ADULT DAY CARE OFFICE	2002	477		5	16	16	16	53
54	CABINETS & COUNTERTOPS	2002	1,105		15	6	6	6	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
2									2
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4									4
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
2									2
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4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,087,826	$ 36,280		$ 33,553	$ (2,727)	$ 192,844	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 224,416	$ 26,961	$ 27,075	$ 114	10	$ 146,031	71
72	Current Year Purchases	46,491		3,268	3,268	10	3,268	72
73	Fully Depreciated Assets	350				10	350	73
74								74
75	TOTALS	$ 271,257	$ 26,961	$ 30,343	$ 3,382		$ 149,649	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 MERCURY SABLE	2001	$ 23,123	$ 4,172	$ 7,708	$ 3,536	5	$ 11,562	76
77	FACILITY	1997 DODGE 2500	1997	24,090	2,409	2,409		5	24,090	77
78	FACILITY	FALCON	1998	5,000				5	5,000	78
79	FACILITY	1999 DODGE MAXIWAGON	1999	25,800	3,225	3,225		5	5,241	79
80	TOTALS			$ 78,013	$ 9,806	$ 13,342	$ 3,536		$ 45,893	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,437,096	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,047	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,238	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,191	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 388,386	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NONCARE AUTO 1998	$ 26,856	$ 3,536	$ 14,094	86
87	NONCARE PORTION OF LAND	838,040			87
88	NONCARE BLDG 1994	1,496,500	37,410	243,167	88
89	NONCARE LEASEHOLD	110,290	12,132	42,670	89
90	NONCARE EQUIPMENT	335,144	40,371	217,871	90
91	TOTALS	$ 2,806,830	$ 93,449	$ 517,802	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation-Pr				11,788			5
6								6
7	TOTAL				$ 11,788 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 15,140 Description: Nursing $13153 , Activity $1553, Administration $171, Home Office Allocation $263
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	2,282	$ 90,009	$ 0	2,282	$ 90,009	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		267	6,485	0	267	6,485	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		1,967	94,423	811	1,967	95,234	4
5	Physician Care		visits				0			5
6	Dental Care		visits				0			6
7	Work Related Program		hrs				0			7
8	Habilitation		hrs				0			8
9	Pharmacy		# of prescrpts				468,960		468,960	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs				0			10
11	Academic Education		hrs				0			11
12	Exceptional Care Program						0			12
13	Other (specify):									13
14	TOTAL			$	4,516	$ 190,917	$ 469,771	4,516	$ 660,688	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA ST JOSEPH CENTER **#** 0041871 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,805,729	$	1
2	Cash-Patient Deposits	81,389		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,148,529		3
4	Supply Inventory (priced at)	433,891		4
5	Short-Term Investments			5
6	Prepaid Insurance	134,839		6
7	Other Prepaid Expenses	281,248		7
8	Accounts Receivable (owners or related parties)	257,083		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,142,708	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,232,107		12
13	Land	7,869,734		13
14	Buildings, at Historical Cost	70,095,577		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,805,416		16
17	Accumulated Depreciation (book methods)	(36,531,116)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	37,932		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,542,473		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 66,052,123	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,194,831	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,102,058	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	579,646		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,523,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	173,680		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	18,305		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37		1,118,274		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,515,276	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,515,276	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 78,679,555	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,194,831	$	48

***(See instructions.)**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 36,962,476	1
2	Restatements (describe):		2
3	**Adjustment fo Reconcile Consolidated Opening Equity**	42,288,776	3
4	**and Consolidated Net Income to Nursing Facility**		4
5	**Amounts**		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 79,251,252	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(571,697)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PRIOR YR ADJ - DEPREC**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (571,697)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 78,679,555	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,333,625	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,333,625	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	357,581	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 357,581	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	107,598	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	468,553	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 576,151	23
	D. Non-Operating Revenue		
24	Contributions	23,107	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,107	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	13,089	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,089	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,303,553	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,120,248	31
32	Health Care	2,219,514	32
33	General Administration	1,819,455	33
	B. Capital Expense		
34	Ownership	181,373	34
	C. Ancillary Expense		
35	Special Cost Centers	468,960	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,875,250	40
41	**Income before Income Taxes (line 30 minus line 40)****	(571,697)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (571,697)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,076	2,224	$ 54,404	$ 24.46	1
2	Assistant Director of Nursing	1,816	2,008	40,234	20.04	2
3	Registered Nurses	13,783	14,643	351,143	23.98	3
4	Licensed Practical Nurses	22,802	23,727	318,788	13.44	4
5	Nurse Aides & Orderlies	82,071	88,842	802,928	9.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,041	3,474	34,112	9.82	8
9	Activity Director	1,971	2,151	25,117	11.68	9
10	Activity Assistants	4,877	5,137	41,055	7.99	10
11	Social Service Workers	4,000	4,443	53,592	12.06	11
12	Dietician					12
13	Food Service Supervisor	3,972	4,484	58,150	12.97	13
14	Head Cook	7,474	8,318	71,747	8.63	14
15	Cook Helpers/Assistants	19,241	20,382	134,531	6.60	15
16	Dishwashers					16
17	Maintenance Workers	7,175	7,854	83,179	10.59	17
18	Housekeepers	11,265	12,472	100,602	8.07	18
19	Laundry	11,099	12,455	100,073	8.03	19
20	Administrator	1,904	2,080	63,581	30.57	20
21	Assistant Administrator					21
22	Other Administrative	2,784	3,202	47,898	14.96	22
23	Office Manager					23
24	Clerical	4,494	4,708	39,956	8.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,584	3,868	71,653	18.52	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	2,113	2,201	21,100	9.59	32
33	Other(specify)	1,521	1,766	26,516	15.01	33
34	TOTAL (lines 1 - 33)	213,063	230,439	$ 2,540,359 *	$ 11.02	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	143	$ 10,393	1, 3	35
36	Medical Director		7,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	32	1,142	10, 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,855	11, 3	44
45	Social Service Consultant	10	561	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	222	$ 21,751		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	445	$ 22,997	10, 3	50
51	Licensed Practical Nurses	2,892	104,067	10, 3	51
52	Nurse Aides	213	4,956	10, 3	52
53	TOTAL (lines 50 - 52)	3,550	$ 132,020		53

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Parsek	Admin.	0	$ 63,581
Other	Other Admin.	0	114,370
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 177,951

B. Administrative - Other

Description	Amount
Miscellaneous	$ 8,817
Corp Service Fee	161,491
Mgmt Fee	257,129
Mgmt Fee Interest	247,116
TOTAL (agree to Schedule V, line 17, col. 3)	$ 674,553
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 426
Purchased Service	Various	
Purchased Service	Various	
Accounting	Various	383
Professional Services	Various	111
Consulting	Various	1,142
Consulting	Various	1,855
Consulting	Various	561
Consulting	Various	10,393
Consulting	Various	22,148
Consulting	Various	63,888
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 100,907

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 737
Unemployment Compensation Insurance	0
FICA Taxes	101,573
Employee Health Insurance	127,574
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Other Benefits	435,860
	0
	0
Home Office Allocation	44,377
TOTAL (agree to Schedule V, line 22, col.8)	$ 710,121

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 55)	
Dues & Subscriptions	13,116
Advertising & Public Relations	
Home Office Allocation	3,857
Less: Public Relations Expense	( )
Non-allowable advertising	(796)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,177

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,044
Seminar Expense	0
Business Meals	
Home Office Allocation	4,821
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,865

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA ST JOSEPH CENTER # 0041871 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **5048 - Life Service Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **120**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,782** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,076**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.